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No. 97-1489

IN THE

Supreme Court of the United States

October Term, 1998

YOUR HOME VISITING NURSE SERVICES, INC.,
Petitioner,
v.
DONNA E. SHALALA,
Secretary of Health and Human Services,
Respondent.

BRIEF OF *AMICI CURIAE*

Oklahoma Hospital Association
Oregon Association of Hospitals & Health Services
Louisiana Hospital Association
Washington State Hospital Association
THA – An Association of Hospitals and Health Services
Texas Association of Hospitals & Healthcare Organizations
Certus Corporation

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QUESTION PRESENTED

Whether specific consequences of insulating the reopening process from review should be considered in determining if there is jurisdiction for review by administrative or judicial bodies of fiscal intermediaries' refusals to reopen Medicare providers' cost reports?

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MOTION FOR PERMISSION TO FILE *AMICUS CURIAE* BRIEF

Because factual circumstances, with a significant bearing on the issues pending before the Court in this case, have developed since the filing of petitioner's opening brief, *amici curiae* request leave of the Court to file this *amicus* brief in support of petitioner, Your Home Visiting Nurse Services, Inc., concurrent with petitioner's reply brief.[1] These facts, which relate to the respondent's non-compliance with a federal court order in Medicare reimbursement litigation in Oklahoma, are fully detailed below. Although not parties, *amici* ask that the Court accept this submission on grounds similar to those set forth under Rule 25.5 of the Supreme Court Rules, which allows parties to file supplemental briefs based on new material not available in time to be included in any earlier brief.

Amici have obtained the written consent of petitioner to the submission of this brief. *See* Appendix A, at App. 1. Respondent Donna E. Shalala, Secretary of Health and Human Services ("the Secretary") has declined to so consent,

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[1] Counsel for *amici curiae* listed on the cover authored this brief in whole. No party, other than *amici curiae*, its members or counsel has made a monetary contribution to the preparation or submission of this brief.

despite the fact that the factual circumstances giving substance to this brief arose *after* the date for filing of petitioner's opening brief.[2]

Further, in withholding consent, respondent has asserted that since the Oklahoma litigation concerned a Medicare regulation not at issue in this case, filing of this *amicus* brief is not warranted. Respondent has misunderstood the purpose of this brief.

Of greatest significance to this case is not the fact that the Oklahoma federal district court invalidated the Secretary's regulation. Rather, it is the Secretary's position, as taken in briefing and oral argument which occurred in September 1998, after opening briefs were filed herein, that she can refuse to advise fiscal intermediaries that her regulation had been declared void *ab initio*, *i.e.*, that it had *never* been a valid interpretation of the law. She bases such refusal on the grounds that giving notice of such invalidation would be tantamount to ordering reopenings of those cost

[2] *Amici* recognize that if the Court accepts this brief, the Secretary may not have the opportunity to file a written reply. However, *amici* do not believe that the Secretary will be prejudiced in that *amici* simply seek to inform the Court of a recently developed factual situation illustrating a result of the Secretary's position that refusals to reopen costs reports are unreviewable. The Secretary cannot claim surprise or unfamiliarity with the facts. *Amici* urge the Court to consider this brief for the light it sheds on the real-world effect of the Secretary's legal position.

report determinations based on the invalidated regulation. She asserts that since the reopening process is solely within *her* purview, the court cannot force her and, by extension, her intermediaries, to take any such action. *Amici* here do not seek to re-litigate the substance of the Oklahoma case. They seek to advise this Court of this factual situation, which illustrates the significant consequences of denying administrative and/or judicial review of a decision not to reopen a cost report. For such reason, *amici* respectfully request that this brief be accepted.

IDENTIFICATION AND INTERESTS OF *AMICI CURIAE*

Amici curiae are six state associations of health care providers and Certus Corporation. The state associations, which include the Oklahoma Hospital Association, Oregon Association of Hospitals and Health Systems, Louisiana Hospital Association, Washington State Hospital Association, THA – An Association of Hospitals and Health Systems (Tennessee), and The Association of Texas Hospitals and Healthcare Organizations, provide leadership and assistance to member hospitals and health systems on financial issues, including Medicare reimbursement issues. Most of the associations' members are providers of health care services under the Medicare program established

pursuant to 42 U.S.C. § 1395 *et seq.*, and rely on Medicare payments as a major source of revenue. The Court's decision in this case as to whether there is administrative and/or judicial review of refusals to reopen a cost report to correct erroneous Medicare reimbursement determinations will have significant financial consequences for these health care providers.

Certus Corporation is a newly formed provider of financial, reimbursement, and regulatory compliance advisory services for hospitals and health systems. Its founders are Medical Reimbursement Advisors, Inc., Certus Enterprises, LLC, Carlson Price Fass & Company, Inc., ELACOR Resources Group, Inc., and Healthcare Financial Advisors, Inc., all nationally known entities that consult with hospitals and health systems on Medicare reimbursement issues.

As is the case with the American Hospital Association and the Federation of American Health Systems, which have also submitted an *amicus* brief in support of petitioner ("AHA brief"), the hospitals and health systems represented by *amici* have the same general interests in the integrity of the Medicare payment process as described in the AHA brief, p. 2. Moreover, these hospitals and health systems have very specific interests arising in response to the

Secretary's longstanding unwillingness, contrary to congressional intent, to adequately reimburse health care providers that treat a disproportionate share of low-income patients. As further explained below, federal district and circuit courts in the jurisdictions where *amici* are located have invalidated a regulation promulgated by the Secretary that illegally limited Medicare disproportionate share reimbursements to such providers. The Secretary has refused to rescind the offending regulation; instead, she has specifically directed her fiscal intermediaries to refuse to reopen cost reports to correct erroneous disproportionate share reimbursement determinations.

Very recently, in an apparent direct contravention of a federal district court order, the Secretary refused to inform her fiscal intermediaries of the federal court decision invalidating the disproportionate share regulation. She has continued to maintain that she has absolute and unreviewable discretion to direct that cost report determinations not be reopened, despite the reliance of those determinations on the invalid regulation. If this Court issues a blanket ruling that there is no avenue of appeal from a refusal to reopen cost report determinations, even in the face of federal court decisions invalidating the regulation invoked to limit disproportionate share reimbursements, then respondent will

have the power to ignore the law unfettered by any check to her arbitrary exercise of authority. If this Court rules in accordance with the Secretary's position, then certain providers such as those represented by *amici* will have no ability to secure the additional reimbursement for treatment of low income patients that Congress intended them to have.

SUMMARY OF ARGUMENT

Amici curiae concur in the arguments set forth in the briefs of petitioner and AHA and do not here restate them. Rather, *amici* seek to bring to the Court's attention recent actions of the Secretary in a case in the United States District Court for the Western District of Oklahoma, *Anadarko Municipal Hospital v. Shalala*, No. CIV-97-0288-A ("*Anadarko*"). In *Anadarko*, the court invalidated, as void *ab initio*, the Secretary's Medicare disproportionate share ("DSH") regulation[3] because it contradicted the clear and manifestly obvious meaning of the congressionally enacted formula for calculating compensation adjustments to providers furnishing care to low-income patients.[4]

[3] 42 C.F.R. § 412.106(b)(4).

[4] Also currently pending before the same district court is *Anadarko Municipal Hospital, et al. v. Shalala*, No. 98-564-A (*"Anadarko II"*). This action, filed after the *Anadarko* decision, involves essentially the same issues and essentially the same plaintiffs, but covers different cost-reporting years. In her answer to the *Anadarko II* complaint, the Secretary avers that she will recalculate the hospitals' DSH adjustments

After the date for filing opening briefs in this case, the Secretary advised the court and parties in *Anadarko* that, in spite of the court's declaration that the regulation was void *ab initio*, she was not required to notify her fiscal intermediaries of its invalidity or of the fact that any determination made by fiscal intermediaries pursuant to the invalidated DSH regulation was inconsistent with applicable law. Absent such notice, the Secretary insists, her fiscal intermediaries are not required to reopen providers' cost reports to correct the consequences of the invalidated regulation. Especially when considered in conjunction with a prior ruling issued by the Secretary in 1997 in which she specifically instructed intermediaries *not* to reopen settled cost reports to correct reimbursements based on the invalid DSH regulation, the Secretary's recent actions have disturbing implications for our legal system. Indeed, the Secretary's actions in the *Anadarko* case provide an actual illustration of the kind of abuses which will arise out of insulating reopening determinations from review by any administrative or judicial body. The Court should take into account the recent events in *Anadarko* when considering whether some type of review should be available to ensure

in accordance with HCFA Ruling 97-2 (the Ruling that limits reopenings to cost reports not yet finalized as of Feb. 27, 1997).

that a refusal to reopen a provider's cost report is not arbitrary and capricious or an abuse of discretion.

ARGUMENT

I. By Seeking To Insulate Her Reopening Decisions From Judicial Scrutiny In *Anadarko*, The Secretary Seeks To Preserve Her Longstanding Hostility To The Congressional Mandate To Adjust Compensation For Providers That Treat A Disproportionate Share Of Low-Income Patients.

In order for the Court to appreciate the significance of the Secretary's actions in *Anadarko*, it is important to understand how the Secretary's DSH regulation failed to reflect the congressional mandate to provide additional reimbursement to health care providers serving the poor and how the Secretary, through her current no-reopening policy, is still seeking to avoid that congressional mandate.

In 1983, Congress enacted a statute, 42 U.S.C. § 1395ww(d)(5)(C)(i) ("Medicare statute"), which directed the Secretary to adjust Medicare payments to hospitals serving "a significantly disproportionate number of low-income patients" in recognition of the fact that those hospitals were incurring greater costs as a result. Under the Medicare statute, "low-income patients" include patients "eligible for" Medicaid. The

Secretary, however, declined to make such an adjustment. 48 Fed. Reg. 39,783 (1983).

In response to the Secretary's failure to provide a DSH adjustment, Congress *directed* the Secretary to develop and publish a DSH definition and identify hospitals that met that definition by December 31, 1984. Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2315(h), codified at 42 U.S.C. § 1395ww note. By July of 1985, the Secretary had still not complied with this congressional mandate, which resulted in a court order directing the Secretary to implement the DSH statutory provision. *See Samaritan Health Center v. Bowen*, 636 F. Supp. 503 (D.D.C. 1985). In 1986, after the Secretary issued extremely narrow DSH criteria (50 Fed. Reg. 53,398-53,400 (1985)), Congress took the extraordinary step, in amending the Social Security Act, of prescribing a specific statutory definition of DSH hospitals.

As amended, the Medicare statute directs the Secretary to furnish an additional payment to hospitals that serve "a significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Hospitals qualify under this standard if their "disproportionate patient percentage" exceeds a certain threshold, and the amount of the additional DSH payment for qualifying hospitals depends on the extent to which their disproportionate patient percentage exceeds the

threshold. 42 U.S.C. § 1395ww(d)(5)(F)(v), (vii). The definition of "disproportionate patient percentage"[5] under the Medicare statute uses *eligibility* for Medicaid as a proxy measure for quantifying the low-income status of patients.

On May 6, 1986, the Secretary, without following the advance notice and comment procedures of the APA, issued an interim final regulation to implement the statutory DSH payment (42 C.F.R. § 412.106). *See* 51 Fed. Reg. 16,772. The Secretary took the position that days would not be counted as Medicaid days under 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), even if they were hospital days attributable to patients "eligible for" Medicaid, if the days were not actually paid for by

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[5] ...the sum of –

(I) the fraction (expressed as a percent-age), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under Title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title, and

(II) the fraction (expressed as a percent-age), the numerator of which is *the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX*, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(emphasis added).

Medicaid. For example, the Secretary's regulation excluded hospital days attributable to patients eligible for Medicaid if those days were beyond the length-of-stay or day limits[6] established for *payment* purposes by a few state Medicaid agencies (including the agencies in the states in which the members of *amici* associations are located). Therefore, for purposes of calculating the DSH percentage, the Secretary defined Medicaid covered days as only those days for which benefits were actually payable under Medicaid, rather than those days for which a patient was eligible for Medicaid even if Medicaid did not actually pay for those days. *See* 51 Fed. Reg. 16,777; *see also* 51 Fed. Reg. 31,460-61. By calculating the DSH percentage so as to exclude days not actually covered by Medicaid, the Secretary reduced the disproportionate patient percentage for health care providers represented by *amici*. The resulting effect has been to deny those providers millions of dollars of additional reimbursement to which they are entitled by the Medicare statute.

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[6] The State of Oklahoma, for example, pays hospitals on a *per diem* basis, subject to a day limit. It limits the number of days for which it will make payment to hospitals for inpatient hospital services furnished under the Medicaid program. A hospital does not receive any additional payment for inpatient services provided to a patient hospitalized after the day payment limit is exhausted, even though the patient remained eligible and was covered for other types of services. The state Medicaid agencies in Oregon, Louisiana, Tennessee, and Texas apply similar limiting methodologies.

Over the past few years, the Secretary's DSH regulation has been challenged and ruled invalid by the Fourth, Sixth, Eighth and Ninth Circuits. *See Cabell Huntington Hosp., Inc. v. Shalala* 101 F.3d 984 (4th Cir. 1996); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Deaconess Health Srvs. Corp v. Shalala*, 912 F. Supp. 438 (E.D. Mo. 1995), *aff'd and adopted*, 83 F.3d 1041 (8th Cir. 1996); and *Jewish Hosp. Inc. v. Dep't of Health & Human Srvs.*, 19 F.3d 270, 276 (6th Cir. 1994). Each of these courts has found the Secretary's DSH regulation to be contrary to the clear language of the Medicare statute as enacted by Congress in 1986. Providers, including those represented by *amici*, have had to repeatedly bring legal actions in the above courts, as well as federal district courts in Texas and Oregon[7] and in *Anadarko* in Oklahoma, to challenge the Secretary's hostile attitude to the concept of DSH adjustments and her refusal, from the very beginning, to follow the Congressional mandate.

As further evidence of her hostility to the DSH adjustment and the will of Congress, the Secretary has published instructions to fiscal intermediaries purporting to

[7] *Incarnate Word Health Srvs. Fort Worth Healthcare Corp. v. Shalala*, CIV-3:95-851-R (N.D. Tex. July 25, 1997); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, No. 94-754-HA (D. Or. May 30, 1997).

implement the recent circuit court rulings, but which unlawfully restrict those rulings. For example, after the Sixth and Eighth Circuits' decisions, the Secretary issued instructions that were directly at odds with the court holdings. *See* Appendix B, at App. 2. Further, despite repeated judicial declarations that her regulation was contrary to the Medicare statute, the Secretary has continued to direct her intermediaries to deny provider requests for reopening of a cost report to correct the DSH adjustment.[8] By asserting that intermediary denials of reopenings (including denials pursuant to her directives) are not reviewable by any administrative or judicial body, the Secretary has effectively been able to avoid her statutory obligation to fully reimburse DSH providers.

In supposed acquiescence to the court decisions, the Secretary issued HCFA Ruling 97-2 on February 27, 1997.[9] This ruling provided that HCFA must calculate DSH adjustments in keeping with the law as declared by the court decisions, but that the ruling only applied prospectively to

[8] The Secretary takes this position even though her own regulations state that reopenings are mandatory if an intermediary is advised that a final reimbursement determination had been made contrary to law. *See* footnote 10, *infra*.

[9] HCFA, the Health Care Financing Administration, is an office within the Department of Health and Human Services which serves as the Secretary's agent.

cost reporting periods beginning on or after February 27, 1997 or to cost reports not yet finalized as of that date. As for previously settled cost reports periods still within the three-year reopening period, the ruling forbid fiscal intermediaries from reopening the DSH adjustment to conform to the Circuit Court decisions.

II. The Secretary's Continuing Hostility To The DSH Congressional Mandate Is Evidenced By Her Recent Actions In *Anadarko*, Where She Predicates Her Scheme For Precluding Corrective DSH Adjustments On Being Able To Arbitrarily Declare And Pursue A No-Reopening Policy That Is Not Reviewable By Any Administrative Or Judicial Body.

On April 13, 1998, the federal district court in Oklahoma granted the *Anadarko* plaintiffs' motion for summary judgment. In its order, the court held that the DSH regulation was void *ab initio*, that the Secretary was under a congressionally imposed obligation to issue a regulation in accordance with the Medicare statute, and that HCFA Ruling 97-2 did not meet the Secretary's obligation to comply with applicable law. In light of these holdings, the court retained jurisdiction over the case and ordered the Secretary to rescind the DSH regulation and to report quarterly to the court on the

status of rescission and of any successor regulation. *See* Appendix C, at App. 8.

On July 13, 1998, the Secretary filed her first quarterly report with the court. *See* Appendix D, at App. 26. Although the court had ordered the Secretary to document the status of *rescission* of the DSH regulation and implementation of a successor regulation, the Secretary's report made no reference to rescission. Instead, the report referred to the Secretary's May 8, 1998, Notice of Proposed Rulemaking ("NPRM"). This NPRM purports to *revise* the prior DSH regulation to include in the calculation of the DSH percentage all days on which a patient was eligible for Medicaid, regardless of whether particular items or services were covered or paid for under an approved state Medicaid plan. NPRM, 63 Fed. Reg. 25,576 at 25,595, 25,606. However, this *revised* regulation applies only to cost reporting periods beginning on or after October 1, 1998. The Secretary states in the NPRM that HCFA Ruling 97-2 would continue to apply to cost reporting periods beginning before October 1, 1998. The Secretary's proposed rule has been finalized. July 31, 1998 Final Rule, 63 Fed. Reg. 40,954, 40,984-85.

In other words, according to the Final Rule, the DSH regulation invalidated by the *Anadarko* court, as well as

federal courts in the jurisdictions in which *amici* members are located, will continue to govern the calculation of the DSH adjustment unless the provider's cost report was not yet settled by its fiscal intermediary as of February 27, 1997, or the provider had an appeal from a cost report determination pending as of February 27, 1997. 63 Fed. Reg. at 25,595; 63 Fed. Reg. at 40,985. The new regulation does not recognize that the prior interpretation was invalid. On the contrary, it specifically preserves the effect of the prior invalid DSH regulation by maintaining HCFA Ruling 97-2 in place and thus preventing, even within the three-year time period for reopening, the reopening of cost reports involving erroneously calculated DSH adjustments settled prior to February 27, 1997. Clearly, the Secretary has continued to utilize her control over the reopening process, and the lack of review thereof, to deny the reimbursement adjustments that she has been ordered, by Congress and the courts, to make.

Based on the Secretary's failure to rescind the invalid regulation and her decision to limit the applicability of the new regulation to prospective cost reporting periods, the *Anadarko* plaintiffs filed a motion on August 14, 1998, seeking an order enforcing the court's decision. As one means of enforcing the court's prior order, plaintiffs asked the court to order the Secretary to inform her fiscal

intermediaries that the DSH regulation had been declared void since its inception and that determinations made pursuant to it were inconsistent with applicable law.

In her September 17, 1998, response to plaintiffs' motion, the Secretary argued that the court could not order her to instruct her intermediaries about the invalidity of the DSH regulation because doing so would be tantamount to the court ordering reopening of cost reports determinations premised on the invalid regulation.[10] The Secretary insisted that the court cannot issue such an order because her decision not to reopen cost reports is unreviewable.[11]

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[10] Under 42 C.F.R. § 405.1885(a), a final determination, whether made by an intermediary, a hearing officer, the PRRB, or the Secretary herself, may be "reopened" by the decision-maker either on the decision-maker's own initiative or at the request of the provider, to revise any matter at issue in the decision. Any request to reopen must be made within three years of the date of the decision. Thus, subsection (a) of 42 C.F.R. § 405.1885 governs reopenings that are discretionary, but subject to certain standards. Subsection (b) provides for mandatory reopening. A determination made by an intermediary *must* be reopened if, within the three year time period, HCFA notifies the intermediary that the intermediary's determination was inconsistent with the applicable law, regulations, or general HCFA instructions. Clearly, any determination made pursuant to a DSH regulation which was invalid since its inception would have been contrary to applicable law.

[11] Incredibly, the Secretary also argued that "retroactivity" was not required because, she asserted, her regulation was the law in the Tenth Circuit until February 27, 1997, the date that she issued HCFA Ruling 97-2 in purported acquiescence with prior court rulings invalidating the regulation. With this assertion, she attempts to write the *ab initio* portion

Oral argument on the *Anadarko* plaintiffs' motion was heard on September 25, 1998. The court has not yet issued a decision.

III. The Secretary's Recent Actions In Response To The *Anadarko* Decision Illustrate The Danger To The Rule Of Law Posed By Her Desire To Shield Her Reopening Determinations From Judicial Review.

Through her actions in response to the *Anadarko* court order invalidating her DSH regulation *ab initio*, that is, her refusal to rescind the regulation, her refusal to notify her fiscal intermediaries of the court decision invalidating the regulation and her refusal to reopen cost reports settled under the invalid regulation, the Secretary seeks to preserve absolute and unfettered discretion to deny providers the DSH adjustments which they are statutorily entitled to receive. When confronted with the inherent inconsistency between her actions and the court's declaration that her DSH regulation has been illegal since it inception in 1986, the Secretary asserts that the court has no power to order her to rescind the regulation or to notify her agents of its illegality because any such action would ultimately lead, *under the*

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of the *Anadarko* "void *ab initio*" declaration completely out of the picture.

terms of her own reopening regulation, to reopening of cost reports. The court does not have this power, she posits, because the reopening process is solely within her purview and not subject to judicial scrutiny regardless of how arbitrarily she may administer the regulatory reopening process.

Further, the Secretary argues, allowing review of reopening denials would violate the 180-day time limit by which providers must appeal a final reimbursement determination. As fully argued in the AHA brief, pp. 10-14, however, the Secretary's own regulation[12] contemplates that adjustments to reimbursement decisions will occur long after deadline for appeals. Such regulation also "evidences the Secretary's conclusion that the need for accuracy in the reimbursement determination should override the finality concerns . . .". AHA brief, p. 11. The Secretary's reopening rules clearly contemplate reopenings of determinations that

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[12] 42 C.F.R. § 405.1885. *See* footnote 10, *supra*. The "parade of horribles" argument (*i.e.*, if providers have their way, no decision by the Secretary would ever be final) set forth by the Secretary in the *Anadarko* briefing is disingenuous. As the Secretary herself recognizes, the three-year time period for reopenings is a built-in limitation. 42 C.F.R. § 405.1885. *See Memorial Hospital v. Sullivan*, 779 F. Supp. 1410, 1412 (D.D.C. 1991) ("the Secretary's fear of destroying the finality of decisions is not present here. Under 42 C.F.R. § 405.1885(a), a provider must reopen . . . within three years . . . and there is no fear that the decision . . . will spawn a plethora of such requests.").

have been made contrary to applicable law. At the very least, in the jurisdictions where federal courts have invalidated the DSH regulation as contrary to the 1986 Congressional mandate, the Secretary must accept those court decisions as the rule of law. She cannot be allowed to utilize the 180-day appeal deadline as grounds for asserting that a court is powerless to enforce the rule of law inherent in its own decision. She cannot avoid consequences of the court's decision on the grounds that enforcement would interfere with what she claims is her unfettered discretion to direct intermediaries to deny reopening requests, even where the determination sought to be reopened was rendered contrary to law. This is indeed a dangerous argument, which subjects the rule of law to the Secretary's arbitrary and capricious whim.

If the Secretary is permitted to act as she is attempting to do in *Anadarko*, then no final determination can ever be reopened, even if its legal underpinnings are judicially declared void from their inception as violative of the Congressional mandate, unless the Secretary decides in her unfettered discretion that she (or fiscal intermediaries acting at her direction) wish to allow reopening. The Secretary's unsound reasoning offered in *Anadarko* makes meaningless the standards purporting to govern reopening decisions as set

forth in her own reopening regulation, and allows the Secretary to ignore such standards with impunity.

IV. In Her Desire To Further Preclude Reopenings To Correct Determinations Made Pursuant To The Invalidated DSH Regulation, The Secretary Appears To Be Restricting Reopenings For Previously Allowable Adjustments.

The Secretary's recent actions in *Anadarko* establish that she is absolutely determined not to correct her prior erroneous, illegal determinations of DSH adjustments, and that she believes she can accomplish her goals by relying on her unfettered discretion over the reopening process and her unreviewable instruction not to reopen those determinations. Her dedication to this contention has even caused her to take the position that reopenings will no longer be allowed to correct errors for which reopenings had previously been routinely allowed, such as adjusting Medicaid paid days, which all parties agreed should have been part of the DSH calculation under any interpretation of the statute, but which were erroneously calculated.[13] Thus, the Secretary is apparently willing to arbitrarily restrict the reopening process

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[13] Although asked over a year ago to confirm, in writing, whether it really intends such an inexplicable change in policy, HCFA has still failed to clarify its interpretation. *See* Appendix E, at App. 29.

in order to preserve the unlawful effect of her invalidated DSH regulation. The Secretary knows that, under her own regulations and under HCFA Ruling 97-2, a proper reopening of the Medicaid paid days figure would allow a provider to insist that the DSH adjustment be calculated in accordance with the law as enacted by Congress. Rather than compensating providers according to the law, the Secretary seeks to arbitrarily restrict the reopening process to prevent a provider from securing a new final DSH determination that would be subject to HCFA Ruling 97-2 and the Secretary's own view of the appeal process.[14]

If the Secretary's reopening decisions are entirely unreviewable, then, as the *Anadarko* case demonstrates, the Secretary can continue to arbitrarily preclude reopenings which do not secure recoupment for the Medicare program, even when the determinations for which review is sought are

[14] The Secretary herself has provided for appeals from revised Notices of Program Reimbursement issued pursuant to a reopening. 42 C.F.R. § 405.1889. That is, once specific reimbursement findings are reopened, a provider has issue-specific appeal rights. The provider can appeal to the PRRB the result of the reopening, including any adjustment made in a revised NPR. *Id.* Thus, if a cost report is reopened to adjust *Medicaid-paid* days, a new DSH calculation/adjustment would result. The provider could pursue an appeal of that new calculation/adjustment to add in *Medicaid-eligible* days because the appeal would be issue specific; *i.e.*, related to the matter of the new calculation/adjustment.

contrary to law. As the AHA notes, "while this approach may be financially beneficial to the government, it is clearly inconsistent with the Secretary's obligations under the Medicare statute and is patently unfair to providers that have served Medicare beneficiaries with the expectation of payment in accordance with the law." AHA brief, p. 19.

CONCLUSION

Amici urge the Court to consider the Secretary's actions and positions taken in *Anadarko* for the bright light they shed on the real-world effect of barring administrative and judicial review of reopening decisions. The Secretary cannot be allowed to claim unfettered discretion over the reopening process and thereby avoid the consequences of judicial decisions, which have found her interpretation of the Medicare statute to be contrary to law. To protect the rule of law, the Court should adopt the position of petitioner, as supported by AHA *amici*, and find PRRB and/or federal district court jurisdiction to review a denial of reopening requests.

Respectfully submitted this 22nd day of October, 1998.

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APPENDIX A

WRITTEN CONSENT OF PETITIONER

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October 12, 1998

VIA FACSIMILE AND FEDERAL EXPRESS NO. 3838128136

Sanford E. Pitler
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Re: Your Home Visiting Nurse Service Inc. v.
Secretary HHS
Case No. 97-1489
Amicus Curiae Brief

Dear Mr. Pitler:

The information you requested is being copied and will be sent to you via Federal Express today. My client agrees to your participation in regard to the above-captioned matter. Please consider this letter as written permission.

The telephone number for Lisa Blatt is (202) 5414-2251.

If you have any questions, please feel free to contact my office.

Sincerely,
/s/
Diana L. Gustin

cc: Ms. Betty Leake, YHVNS

APPENDIX B

SECRETARY'S INSTRUCTIONS

DEPARTMENT OF HEALTH & HUMAN SERVICES
FKA122

Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207-5187

OCT 20 1994

Director,
Bureau of Program Policy

Effectuating Sixth Circuit Decision in Jewish Hospital

HCFA Regional Office,
Atlanta

As you may be aware Jewish Hospital had contested HCFA's interpretation of the regulations at 42 CFR 412.106 concerning the calculation of disproportionate share payments (DSH). In calculating payments HCFA determined the percentage of low income patients as the number of inpatient days attributable to beneficiaries who were entitled to both Medicare Part A and Federal Supplemental Security Income divided by the total number of Medicare patient days, plus the number of paid Medicaid patient days divided by total patient days. Previously, medicaid patient days were interpreted as those days for which a patient qualified for and received payments for service. HCFA has stood by this policy as outlined in the September 3, 1986 Federal Register Vol.51, No. 170, 31460.

This case was decided in favor of Jewish Hospital on March 18, 1994, by the United States Court of Appeals for the Sixth Circuit. Recently the Sixth Circuit has denied the rehearing request, thereby leaving intact the decision in

Jewish Hospital Inc. v. Secretary of Health and Human Services, 19 F. 3d 270 (1994).

As a result, you will need to contact the fiscal intermediaries servicing hospitals within the jurisdiction of the Sixth Circuit (Kentucky, Michigan, Ohio and Tennessee) to notify calculations for the affected hospitals.

1. In the future, DSH calculations will be determined using the Court's methodology. This means that the calculation of the DSH adjustment would include inpatient hospital days which would have been paid by Medicaid but for State coverage limitations on such days. The calculation would not include patient days which are not within the limited service packages for illegal aliens (emergency services), qualified low-income pregnant women (services related to pregnancy), or COBRA continuation beneficiaries. In addition, intermediaries should be made aware that the decision should be effectuated by compliance with the narrow issue considered by the Court, i.e. intermediaries should not add to the calculation any patient days which would not have been included because of reasons other than number-of-day coverage limits.

2. Presently, use the court's methodology to recompute past DSH payments for those cost years for which a Notice of Program Reimbursement has not, as yet, been issued or it has been issued and there is a

jurisdictionally proper appeal.

3. We will deny any requests for the reopening of fiscal periods for which final payment has been made and the time has passed for simple reconsideration or appeal.

The above policies will go into effect from July 1, 1994, the beginning of the first quarter following the Sixth Circuit decision. If you have any further questions regarding this issue please contact Anne Tayloe at (410) 966-4546.

/s/
Thomas A. Ault

DEPARTMENT OF HEALTH & HUMAN SERVICES
FKA-31

Health Care
Financing Administration
MEMORANDUM

FROM: Director SEP 30 1996
Bureau of Policy Development

SUBJECT: Effectuating Eighth Circuit Decision in Deaconess Health Services Corporation

TO: HCFA Regional Office,
Chicago
Dallas
Denver
Kansas City

As you may be aware, Deaconess Health Services Corporation challenged HCFA's interpretation of the regulations at 42 CFR 412.106 concerning the calculation of disproportionate share payments (DSH). In calculating those payments, HCFA determined the percentage of low income patients as the number of inpatient days attributable to beneficiaries who were entitled to both Medicare Part A and Federal Supplemental Security Income divided by the total number of Medicare patient days, plus the number of paid Medicaid patient days divided by total patient days. Deaconess challenged HCFA's determination of Medicaid patient days. Previously, Medicaid patient days were interpreted as those days for which a patient qualified for and received Medicaid payments for inpatient hospital service. HCFA has stood by this policy as outlined in the September 3, 1986 Federal Register Vol. 51, No. 170, 31460.

This case was decided in favor of Deaconess Health Services Corporation on May 22, 1996, by the United States Court of Appeals for the Eighth Circuit. In a short opinion, the Eighth Circuit affirmed the District Court decision in Deaconess Health Services Corporation v. Secretary of Health and Human Services, 83 F.3d 1041 (1996). Therefore, the Secretary is bound by this decision for providers within the jurisdiction of the Eighth Circuit.

As a result, you will need to contact the fiscal intermediaries servicing hospitals within the jurisdiction of the Eighth Circuit (Arkansas, Iowa, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota).

1. In the future, DSH adjustments for hospitals within the jurisdiction of the Eighth Circuit will be determined using the methodology which resulted from the decision in Jewish Hospital Inc. v. Secretary of Health and Human Services, 19 F.3d 270 (1994). This means that the calculation of the DSH adjustment would include inpatient hospital days which would have been paid by Medicaid but for State coverage limitations on such days. The calculation would not include patient days which are not paid by Medicaid for other reasons, including patient days which are paid in full by third parties, days paid by Medicare Part A, and patient days which are not within the limited service packages for illegal aliens (emergency services), qualified low-income pregnant women (services related to Pregnancy), or COBRA continuation beneficiaries. In sum, intermediaries should be made aware that the decision should be effectuated by compliance with the narrow issue considered by the Court, and not more broadly; i.e., intermediaries should not add to the calculation any patient days which would not have been included because of reasons other than number-of-day coverage limits.

2. Presently, use this methodology to recompute past DSH payments for those cost years for which a Notice of Program Reimbursement (NPR) has not, as yet, been issued; or for those years in which the NPR has been issued and there is a jurisdictionally proper appeal.

3. Deny any requests for the reopening of fiscal periods for which final payment has been made and the time has passed for simple reconsideration or appeal.

The above policies will go into effect from July 1, 1996, the beginning of the first quarter following the Eighth Circuit decision. If you have any further questions regarding this issue, please contact Anne Rudolph at (410) 786-4546.

/s/
Thomas A. Ault

APPENDIX C

***ANADARKO MUNICIPAL HOSPITAL v. SHALALA*, CIV-97-288-A**

COURT ORDER DATED APRIL 13, 1998

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF OKLAHOMA

ANADARKO MUNICIPAL HOSPITAL, et al.	)	
Plaintiffs,	)	No. CIV-97-288-A
v.	)	
DONNA E. SHALALA, SECRETARY DEPARTMENT OF HEALTH AND HUMAN SERVICES,	)	
Defendant.	)	

ORDER

Defendant seeks an entry of judgment awarding plaintiffs all of their requested monetary claims for which they provide documentary proof, hoping thereby to rend this case by mooting its issues. Plaintiffs seek a motion for summary judgment awarding them their monetary claims, and declaring 42 C.F.R. § 412.106 void *ab initio*. Defendant responds, arguing that all of plaintiffs' claims should be moot because of the proposed entry of judgment and the issuance of HCFA Ruling 97-2. A hearing on these motions was held on March 3, 1998. The parties were given until April 6,

1998, to file optional supplemental briefs. Both parties have done so.

Procedural History

Plaintiffs, a group of 29 hospitals, brought suit for monetary and declaratory relief against defendant, challenging the validity of defendant's interpretation of 42 U.S.C. § 1395ww(d)(5)(F) in C.F.R. § 412.106(b)(4)(1998). The Provider Reimbursement Review Board ("PRRB") granted an expedited judicial review of the issue. On June 29, 1997, this Court administratively closed this action until July 25, 1997, to allow the parties to obtain a final determination of the action.[1] On September 23, 1997, the parties requested that the Court reopen the action.

Defendant admits that plaintiffs are entitled to relief under a revised interpretation of 42 U.S.C. § 1395ww(d)(5)(F). Although defendant has not vacated or rescinded the challenged regulation, 42 C.F.R. § 412.106, it has published a Health Care Financing Administration ("HCFA") Ruling 97-2 in an attempt to comply with four circuit court decisions that have found 42 C.F.R. § 412.106(b)(4) an impermissible interpretation of the statute.

[1] The Order was subsequently extended to September 23, 1997.

Defendant seeks an entry of judgment to recalculate the Medicare disproportionate share payment adjustment for all requested categories of payment by plaintiffs. Plaintiffs would merely be required to submit documentary proof of their entitlement to payment.

Plaintiffs' motion for summary judgment was filed the same day as defendant's motion for entry of judgment.

Undisputed Facts

Four circuit courts have found 42 C.F.R. § 412.106(B)(4) directly contradicts the clear language of 42 U.S.C. § 1395ww(d)(5)(F), which obliges payment for those days a patient would be eligible for coverage under the state Medicaid plan, rather than entitled to coverage. Eligibility refers to the patient's right to receive funds under the Medicaid plan, rather than his actual receipt of funds under the plan. See Cabell Huntington Hospital, Inc. v. Shalala, 101 F.3d 984 (4th Cir. 1996); Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261 (9th Cir. 1996); Deaconess Health Serv. Corp. v. Shalala, 912 F.Supp. 438 (E.D.Mo. 1995), aff'd and adopted, 83 F.3d 1041 (8th Cir. 1996); Jewish Hospital, Inc. v. Department of Health & Human Serv., 19 F.3d 270, 276 (6th Cir. 1994). See also Incarnate Word Health Services Fort Worth Healthcare Corp. v. Shalala, CIV-3:95-851-R (N.D. Tex. July 25, 1997);

Legacy Emanuel Hospital & Health Center v. Shalala, Nos. 94-754-HA (D.Or. May 30, 1997). Plaintiffs' Motion for Summary Judgment, Attachments I, J. In response to this litigation, HCFA issued HCFA Ruling 9702 on February 27, 1997. This ruling provides that HCFA will count those days a patient was eligible for Medicaid regardless of whether the hospital received payment for those days. However, this calculation is prospective only and will be applied to those hospitals who have or have had an appeal pending regarding HCFA's prior interpretation.

Entry of Judgment

Defendant stipulates that it will calculate the reimbursement in accordance with plaintiff's request, which it recognizes is consistent with the four circuits' rulings. Plaintiffs admit that their claims for monetary relief are now moot.

By affidavit of Nancy Edwards, defendant affirms that the four requested categories of days identified by plaintiff will be reimbursed. Defendant's Opposition to Plaintiffs' Motion for Summary Judgment, Ex. 1. Plaintiffs must submit documentary proof for all of their requests to defendant prior to recovering payments. Plaintiffs contend that HCFA Ruling 97-2 contains impermissible language, and that the entry of judgment does not address all of

plaintiffs' claims. As discussed below, defendant's entry of judgment does not moot plaintiffs' remaining claims, and thus the motion is DENIED.

Summary Judgment

Summary judgment is appropriate if the pleadings and affidavits show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). "[A] motion for summary judgment should be granted only when The moving party has established the absence of any genuine issue as to a material fact." Mustang Fuel Corp. v. Youngstown Sheet & Tube Co., 561 F.2d 202, 204 (10th Cir. 1977).

A. Mootness

A court lacks subject matter jurisdiction if there is no live case or controversy. F.E.R. v. Valdez, 58 F.3d 1530, 1532-1533 (10th Cir. 1995). Defendant bears a heavy burden of demonstrating mootness. United States v. W.T. Grant Co., 345 U.S. 629, 633 (1953). "The touchstone of the mootness inquiry is whether the controversy continues to 'touch [] the legal relations of parties having adverse legal interests . . . .'" Cox v. Phelps Dodge Corp., 43 F.3d 1345, 1348 (10th Cir. 1994). "It is well established that what makes a declaratory judgment action 'a proper judicial resolution of a case or

controversy rather than an advisory opinion – is [] the settling of some disputes which affects the behavior of the defendant toward the plaintiff.'" Green v. Branson, 108 F.3d 1296, 1299 (10th Cir. 1977) (internal quotation omitted). A plaintiff must show a good chance of being likewise injured in the future. Id. At 1300.

The Court finds a continuing live case or controversy. The PRRB certified the question of the regulation's validity as well as HCFA's application of the regulation to this Court for review. Plaintiff's Motion for Summary Judgment, Attachment R. Although HCFA has agreed to recalculate the payments to plaintiffs, it has not agreed to invalidate its prior regulation. The Court finds that plaintiffs' declaratory judgment claims are not mooted by HCFA Ruling 97-2 nor by defendant's agreement to recalculate their claims.

The facial validity of the regulation is still a live controversy, unless (1) there is no reasonable expectation that the alleged violation will recur, and (2) interim relief has completely and irrevocably eradicated the effects of the alleged violation. City of Mesquite v. Aladdin's Castle, Inc., 455 U.S. 283, 289 (1982). See also City of New Haven, Conn. V. United States, 809 F.2d 900 (D.C. Cir. 1987) (holding request for fee waiver was mooted by agency's change in position; however, question of the facial validity of

the regulation was a live controversy). "[A]fter years of litigation challenging an administrative regulation, an agency would be able to moot a given lawsuit by promulgating a new regulation." Tallahassee Memorial Regional Medical Center v. Bowen, 815 F.2d 1435, 1450 n. 27 (11th Cir. 1987), cert. Denied, 485 U.S. 1020 (1988). See *e.g.* Nader v. Volpe, 475 F.2d 916, 917 (10th Cir. 1973) (because the violation is capable of repetition, yet evading review, action not moot where agency order expires or is withdrawn.

Here, there is a reasonable expectation that the improper interpretation may be applied in the future, and HCFA Ruling 97-2 does not provide complete relief. Because HCFA Ruling 97-2 is not promulgated pursuant to the Administrative Procedures Act, it is not a formal regulation. Although defendant argues it is a final agency order, it may be rescinded quickly and easily by a subsequent order solely with HCFA's discretion. See *e.g.* Arkansas Medical Soc. Inc. v. Reynolds, 6 F.3d 519, 528 (8th Cir. 1993) (holding DHS reserves the right to set reimbursement rates, thus, it clearly has not met its heavy burden to demonstrate mootness). As discussed below, HCFA has been loath to properly interpret the statute and its Ruling contains impermissible language. The Ruling contains language that continues to favor entitlement over eligibility

as the criterion. Id.; see also Incarnate Word Health Services Forth Worth Healthcare Corp. v. Shalala, CIV-3:95-851-R (N.D. Tex. July 25, 1997). Further, the Ruling does not provide complete relief as it is prospective only. The Court recognizes that the issue of reopening finalized reimbursement orders is not before the court. However, this issue reflects the inadequacy of HCFA's interim order for mootness purposes. Defendant has not yet rescinded the regulation even though HCFA Ruling 97-2 was issued over a year ago. HCFA Ruling 97-2 does not recognize that its prior interpretation was invalid. See *e.g.* Sierra Club v. Cargill, 732 F.Supp. 1095, 1098 (D.Colo. 1990) (holding agency's determination that former standard was legal although voluntarily ceased its interpretation provided no guarantee that it would not revert to improper interpretation). Plaintiffs' Motion for Summary Judgment, Attachment K. Rather, HCFA continues to assert that it was a reasonable interpretation. Id.; see also Alaniz v. Office of Personnel Management, 728 F.2d 1460, 1465 (Fed.Cir. 1984) ("It is clear that no deference is due to an agency interpretation fashioned for the purposes of litigation").

Defendant is under a Congressional obligation to issue a regulation in accordance with the statute. The current regulation is void *ab initio* as discussed below. See *e.g.*

Dixon v. United States, 381 U.S. 78, 70 (1965) (a regulation contrary to statute is a mere nullity). Defendant's continuing hostility towards this interpretation, along with its delay in rescinding the regulation, support plaintiffs' argument that the invalid interpretation may recur. Accordingly, plaintiffs' declaratory judgment claims are not moot.

Even assuming defendant's issuance of Ruling 97-2 somehow moots plaintiffs' declaratory judgment claims, their claims fall within two exceptions of the mootness doctrine. There are three exceptions to the mootness doctrine: (1) failure to rule on an issue will have collateral legal consequences, (2) the mooted issue is capable of repetition, yet evading review, or (3) a party has taken all steps necessary to perfect the appeal and to preserve the status quo before the dispute becomes moot. See *e.g.* B&B Chemical Co. v. United States E.P.A., 806 F.2d 987, 990 (11th Cir. 1986).

Defendant contends that there is no reasonable expectation that it will rescind HCFA Ruling 97-2 and apply an interpretation contrary to the four circuits' rulings. Defendant's history of hostility toward properly interpreting the statute weighs in favor of a reasonable expectation defendant will once again improperly interpret the statute.

Prior to October 1, 1983, hospital services were reimbursed under Medicare on a reasonable cost basis. 42 U.S.C. § 1395f(b). After October 1, 1983, Congress adopted a prospective payment system ("PPS") for reimbursement. This system is based upon a predetermined rate set on a per-discharge basis subject to certain payment adjustments. 42 U.S.C. § 1395ww(d)(5)(F). Nonetheless, the Secretary declined to make the adjustment to a new basis. 48 Fed.Reg. 39,783 (1983). Congress directed the Secretary by December 31, 1984, to develop and publish a disproportionate share definition and identify hospitals that met the definition. 42 U.S.C. § 1395ww note; Deficit Reduction Act, Pub.L. 98-369, § 2315(h), 98 Stat. 494, 1080 (1984). by July 1985, the Secretary had not yet complied with this mandate. A court order was issued directing the Secretary to implement the adjustment. See Samaritan Health Center v. Heckler, 636 F.Supp. 503, 517-18 (D.D.C. 1985). Subsequently, Congress amended the Medicare statute to prescribe a statutory definition of disproportionate share hospitals ("DSH"). Consolidated Omnibus Reconciliation Act of 1985, Pul.L.No. 990272, § 9105 (1986). The Medicare statute directs the Secretary to make an add-on payment for PPS hospitals that serve "a significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). On May 6,

1986, the Secretary adopted regulations implementing the statute and finding that payment would be made only for those days that the patient was entitled to state Medicaid reimbursement, i.e., the days the hospital was actually reimbursed under the state plan. 42 C.F.R. § 412.106(b)(4) (1998). This procedural history has been cited in support for the theory that defendant has been hostile towards the statutory interpretation. See Jewish Hospital, 19 F.3d at 275; Samaritan Health Center, 636 F.Supp. at 517. The Court finds ample evidence that defendant's invalid interpretation is capable of repetition, yet evading review.

Moreover, this action falls within an alternative mootness exception regarding collateral legal consequences. Ortho Pharmaceutical Corp. v. Amgen, Inc., 882 F.2d 806, 810 (3rd Cir. 1989). See generally, Sibron v. New York, 3392 U.S. 40, 53-57 (1968). See also Sule v. Warden, ADX Florence Colorado, 133 F.3d 933 (table, text in Westlaw) 1998 WL 10240 (10th Cir. Jan. 13, 1998) (unpublished disposition cited as persuasive authority pursuant to Tenth Circuit Rule 36.3). Without a ruling regarding the invalidity of the regulation in this district, defendant could inch back to an interpretation contrary to the regulation. The status of the appropriate interpretation in this district would be left within the defendant's discretion. See Arkansas Medical, 6 F.3d at

528. As the Ruling does not apply retroactively and is not a final agency order under the APA, the plaintiffs and other hospitals would be precluded from seeking judicial review of the Ruling regarding prior disallowed claims. The administrative process permitting such a review is a time-consuming and expensive procedure. The Court finds that its failure to rule on the regulation's invalidity would have collateral legal consequences for these and other plaintiffs. Thus, plaintiffs' declaratory judgment claims are not moot.

B. Subject Matter Jurisdiction

Next, defendant contends that this Court lacks subject matter jurisdiction over this case. Judicial interpretation of the Medicaid statute must be certified by the PRRB. Once certified, the Court is not limited in fashioning appropriate remedies in this case. Pursuant to Tallahassee Memorial Regional Medical Center v. Bowen, 815 F.2d at 1450 n. 27, 42 U.S.C. §1395oo does not limit the Court's power to fashion appropriate remedies once judicial review is certified by the PRRB. HCFA's attempt to moot claims regarding this regulation through Ruling 97-2 came after the PRRB certified the regulation's validity to this Court. HCFA cannot now maintain that its Ruling modifies the regulation and simultaneously prevents the plaintiffs from attacking its

contents. The Court finds it has jurisdiction over plaintiffs' claims.

C. HCFA Ruling 97-2

According to a Northern District of Texas case, certain language in HCFA Ruling 97-2 is impermissible and creates ambiguity regarding the definition of eligibility:

> claims by hospitals must 'meet all other applicable requirements,' which include the hospitals verifying with the State 'that a patient was **eligible for Medicaid (for some covered services)** during each day of the patient's inpatient hospital stay.' . . . This Court has clearly stated that the relevant test for days included in the Medicaid low-income proxy calculation is eligibility for Medicaid, **not service coverage**. Insofar as HCFA Ruling 97-2 requires proof of service coverage as proof of eligibility, it contradicts this Court's two Orders in this case and the holdings of the four Circuit Courts that have ruled on this issue.

Incarnate Word Health Services Fort Worth Healthcare Corp. v. Shalala, CIV-3:95-851-R (N.D. Tex. July 25, 1997). The Court agrees. HCFA Ruling 97-2 does not completely eliminate any controversy or ambiguity in defendant's interpretation of 42 U.S.C. §1395ww(d)(5)(F). The Court finds defendant's new interpretation is based on four circuits' rulings, not because HCFA recognizes the regulation's

invalidity. Alaniz, 728 F.2d at 1465 (holding agency interpretation not entitled to deference where issued because of litigation). Accordingly, HCFA Ruling 97-2 does not satisfy its statutory mandate, and contains impermissible language.

D. Void Ab Initio

Four circuit courts and two district courts have ruled that 42 C.F.R. §412.106(b)(4) is an impermissible interpretation of 42 U.S.C. §1395ww(d)(5)(F). This Court agrees. The standard of review of an agency interpretation is governed by Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 843 (1986). First, the issue is whether by looking first to the language of the statute and then if necessary to legislative history, Congress has directly spoken to the precise question at issue. Id. If Congressional intent is clear, the Court and the Agency must give effect to Congressional intent. Id. If Congress has not directly addressed the issue, i.e. the statute is silent or ambiguous, the issue is whether the agency's interpretation is a permissible construction of the statute. Id.

Pursuant to 42 U.S.C. §1395ww(d)(5)(F)(i):

> For discharges ..., the Secretary shall provide,..., for an additional payment amount for each ... hospital which—

> (I) serves a significantly disproportionate number of low-income patients...

A hospital "serves a significantly disproportionate number of low income patients" if the hospital has a disproportionate patient percentage which is defined as:

> (I) the fraction..., the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter..., and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this subchapter, and
>
> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter, and the denominator

> of which is the total number of the hospital's patient days for such period.

42 U.S.C. §1395ww(d)(5)(F)(iv)(l)(ll). The Court finds clear statutory intent that eligibility refers to whether a patient is capable of receiving federal medical assistance or Medicaid. The phrase "the number of the hospital's patient days for such period" modifies the term eligible. The regulation interprets this to mean the days for which the State has paid. Eligibility refers to the qualification for benefits, not their actual receipt. Congress utilized the term "entitlement" in the Medicare proxy, and not in the Medicaid proxy. 42 U.S.C. §1395ww(d)(5)(F). The terms have clearly different meanings and are not designed to be commingled.

Legislative history tells us that all inpatient days for Medicaid-eligible patients regardless of state payment were to be given a cost adjustment. The House Committee in discussing the need for cost adjustments to hospitals serving a large number of low income patients stated that:

> [i]f a patient is eligible for Medicaid *at* any point during his inpatient stay, all days of care attributable to that patient would be counted under the provision, whether or not actually

> paid for by the Medicaid program. (Emphasis supplied).

House Report 241(L) at 17. See Plaintiffs' Motion for Summary Judgment, Attachment E1. Further, the legislative history of Senate Bill 1606 does not limit the number of days to those actually paid by state programs. Id. at Attachment F. Congress directed defendant to adopt a regulation carrying into effect Congress' will. Legal Environmental Assistance Foundation, Inc. v. U.S. E.P.A., 118 F.3d 1467, 1473 (11th Cir. 1997). The regulation adopted by defendant does not express Congressional intent, and thus is a nullity. Id. (citing Dixon v. United States, 381 U.S. 68, 74 (1965)). Congress has directly spoken to the issue and defendant's interpretation is void *ab initio*. See Cabell Huntington Hospital, Inc., 101 F.3d at 990 (holding language of statute clear); Legacy Emanuel, 97 F.3d at 1266 (holding language of statute clear); Deaconess Health Servs., 912 F.Supp. at 447 (holding language of statute clear). Plaintiffs are entitled to judgment as a matter of law.

CONCLUSION

Defendant's Motion for Entry of Judgment is DENIED. Plaintiffs' Motion for Summary Judgment is

GRANTED. Defendant is directed to calculate plaintiffs' adjusted payments in accordance with plaintiffs' request subject to proper documentation. The Court retains jurisdiction of this matter to ensure proper payment.

The Court also declares 42 C.F.R. §412.106(b)(4) is void *ab initio*. The Court orders defendant to report every 3 months in writing to this Court regarding rescission of it and the status of any successor regulation.

IT IS SO ORDERED this 13th day of April, 1998.

/s/
WAYNE E. ALLEY
UNITED STATES DISTRICT
JUDGE

ENTERED ON JUDGMENT DOCKET ON APR 13 1998

APPENDIX D

***ANADARKO MUNICIPAL HOSPITAL v. SHALALA*, CIV-97-288-A**

SECRETARY'S FIRST QUARTERLY REPORT DATED JUNE 10, 1998

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF OKLAHOMA
OKLAHOMA CITY DIVISION

ANADARKO MUNICIPAL HOSPITAL, et al.,	)	
Plaintiffs,	)	
v.	)	Case No. CIV-97-0288-A
DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES,	)	
Defendant.	)	

DEFENDANT'S REPORT TO THE COURT

Pursuant to this Court's April 13, 1998 Order, which directed Defendant to report every three months in writing to this Court regarding rescission of 42 C.F.R. § 412.106(b) (4) and the status of any successor regulation, the Defendant reports the following:

1. On May 8, 1998, the Defendant-Secretary issued a Notice of Proposed Rulemaking (NPRM) entitled, "Medicare Program: Changes to the Hospital Inpatient

Prospective Payment Systems and Fiscal Year 1999 Rates." 63 Fed. Reg. 25576 (1998).

2. This NPRM would amend 42 C.F.R. § 412.106(b) (4) by replacing the Secretary's original interpretation of the Medicaid fraction for the disproportionate patient percentage in section 1886(d) (5) (F) (vi) (II) of the Social Security Act, 42 U.S.C. § 1395ww(d) (5) (F) (vi) (II), with the interpretation declared by this and other courts. 63 Fed. Reg. at 25594-95, 25606. Specifically, the NPRM would revise § 412.106(b) (4) to include each hospital patient day for a patient eligible for Medicaid on such day, regardless of whether particular items or services were covered or paid under an approved State Medicaid Plan. 63 Fed. Reg. At 25595, 25606.

3. The proposed revision to § 412.106(b) (4) would apply to cost reporting periods beginning on or after October 1, 1998. 63 Fed. Reg. At 25595.

4. The May 8, 1998 NPRM addresses the annual update of matters pertaining to the prospective payment system for acute care hospitals participating in the Medicare program. See 42 U.S.C.A. § 1395ww(E) (5) (a). The NPRM

is scheduled to be finalized by August 1, 1998. See 42. U.S.C.A. § 1395ww(e) (5) (B).

Respectfully submitted,

PATRICK M. RYAN
United States Attorney

/s/
KAY SEWELL
Assistant United States Attorney
210 West Park Avenue
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(405) 553-8807

APPENDIX E

LETTER TO HCFA REGARDING CLARIFICATION OF RULING 97-2

LAW OFFICES
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OF COUNSEL
David A. Bennett

July 21, 1997

Via Facsimile and First Class Mail

Ms. Anne Rudolph
Health Care Financing A
Health Care Financing Administration
MS-/C5-06-27
7500 Security Blvd.
Baltimore, MD 21244

Re: Medicare Disproportionate Share
HCFA Ruling 97-2
Reopenings To Include Additional Covered Medicaid Days

Dear Ms. Rudolph:

Thank you for your voice mail message of last week regarding my inquiry as to the meaning of HCFA Ruling 97-2 and the follow-up memorandum dated June 12, 1997. As I explained in my voice mail left for you, my inquiry concerns comments made to me by Mark Smith of Blue Cross of Oklahoma regarding reopenings, a subject that is not covered in the Medicare disproportionate share (DSH) litigation currently under way in Oklahoma. As requested in your voice mail to me, I set forth below the context and my specific question.

As you may know, we have been working with the State of Oklahoma to obtain data regarding paid and denied claims submitted by Oklahoma hospitals to the Oklahoma Medicaid program. While the process of obtaining and analyzing this data has been ongoing, we have filed reopening requests with Blue Cross of Oklahoma. The intent of our reopenings is to add, based on State-supplied documentation, additional paid and covered Medicaid days, that is, days that HCFA agreed to incorporate into the Medicare DSH calculation under the Secretary's interpretation of the DSH statute prior to HCFA Ruling 97-2. Recently, Mr. Smith called and informed me that he would be denying all reopening requests pursuant to HCFA Ruling 97-2. I explained to him that we intended to supply documentation of additional covered days, and that I did not understand HCA Ruling 97-2 or the June 12th memo as precluding a reopening to include

such days. He cited to me his conversation with you and the numbered paragraph 4 in the June 12th memo, which states as follows:

> 4. If a cost report was settled prior to February 27, 1997, and the hospital has not filed a jurisdictionally proper appeal on this issue (Medicaid days), its cost report should not be reopened to recalculate Medicaid days, whether or not the three year period for discretionary reopening has expired. This is true even if the cost report is subsequently reopened for other issues, including other Medicare disproportionate share issues which do not affect Medicaid days. This would include reopenings to recalculate Medicare Part A/SSI days.

Our specific question is this: Does the above quoted paragraph, other portions of the June 12th memo, and/or HCFA Ruling 97-2, preclude a reopening to add Medicaid days to the DSH calculation if HCFA would have included such days under the Secretary's interpretation of the statute prior to the issuance of

HCFA Ruling 97-2? For example, if we can document from State of Oklahoma records that a hospital had paid Medicaid days in excess of the amount used by the fiscal intermediary to finalize the cost report, can a hospital reopen its cost report within the three-year reopening time period, to add the additional paid days?

We would appreciate greatly hearing from you regarding this inquiry as soon as possible. If HCFA is taking the position that no reopenings will be allowed even to include paid Medicaid days, we would appreciate an explanation of HCFA's position. We make this request because our understanding of the Secretary's position on reopenings is that they will be allowed only to the extent that new and material evidence is provided and only in accordance with the law at the time the cost report was finalized. Because the Secretary's Medicaid paid day interpretation of the DSH statute was used to finalize the cost reports in question, it seems appropriate for reopenings to be allowed to include additional days that would be included under that interpretation.

Should you have any questions regarding this inquiry, please contact me at 206-622-5511.

Very truly yours,

BENNETT & BIGELOW, P.S.

/s/
Sanford E. Pitler

SEP:wss

cc: Mr. Mark Smith
Blue Cross of Oklahoma

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